SUMMIT
HEALTH & WELLNESS

New Patient Policies and Procedures

Thank you for choosing Summit Health and Wellness Center for your mental health needs! Our goal is to provide compassionate and attentive behavioral health and wellness to individuals and their families.

On Your First Visit

Please arrive at least 15 minutes prior to your scheduled appointment time. In the event that you are unable to complete the required paperwork prior to your new patient appointment, please arrive 30 minutes early, in order to complete it in the office. **Please bring the following items to your first appointment:**

- Insurance cards and/ or subscriber information
- Legal ID
- DHS or custody papers
- List of all medications

After Hours

If a NON-EMERGENT matter arises after business hours, please leave a voicemail on the answering machine and you will receive a phone call back during regular business hours. If an EMERGENT/ URGENT matter arises after hours, please attend the nearest emergency room or call 911.

Appointments

Patients are seen by appointments only. Our office hours are Monday through Thursday 8:00 am – 5pm and Friday 8:00 am to 12:00 pm. The office is closed on most major holidays. If you are unable to keep your scheduled appointment, please contact our office at (405) 310- 3735 ext. 1# as soon as possible. Our office requires a **24-hour** notice if an appointment needs to be cancelled or rescheduled. If a 24-hour notice is not provided, a charge will be assessed to the patient of the full amount of the scheduled visit. Summit Health and Wellness Center will make every attempt to provide a reminder of your scheduled appointment, but this does not exempt the patient of a missed appointment fee. Should the patient have 3 no show appointments, they may be dismissed as a patient from our clinic. Likewise, should a patient have frequent cancellations, they may be terminated as a patient from Summit Health and Wellness Center. If the patient is more than 10 minutes late to their scheduled appointment, it will need to be rescheduled and it will be considered a missed appointment.

Closings

In the event we need to close the office early, such as in the event of inclement weather, we will call our patients as far in advance as possible. Should you not be able to attend your scheduled appointment due to weather, it will not be considered a missed appointment. There will be a recorded message on our answering machine and post on social media should we need to close the office for any event. Please follow us on Instagram, Facebook, Twitter, and Yelp!

Prescriptions

Refill requests can be requested by having your pharmacy send a refill request to our office, patient portal, or by calling the office. Please allow 72 hours for medication refills to be processed. Please, call 3 days prior of your medication running out. If you have missed appointments and/ or do not have a follow up scheduled, a refill request may be denied. If we are unable to answer the phone, please leave a detailed voicemail stating the patients full name, date of birth, and prescription needed.

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Payment of Services

Payment is due at the time of services. Our providers are on several insurance panels and as a result we will bill your insurance for services rendered. You are responsible for copays, deductibles, co-insurance, and any service your insurance carrier does not cover. It is the patient's responsibility if a referral, form, or authorization is required to be seen in our office prior to their first visit. There will be a $29 fee assessed for any returned checks.

Medical Records

Requests for any medical records must be made in writing. In addition, a HIPAA form must be completed. We ask that you please allow 2 weeks for processing requests for medical records. A fee may be assessed for records requested and will be communicated to the patient once records are requested.

Forms/ Letters

We understand that there are several reasons patients need letters and forms completed by their medical provider. There will be a fee associated with these requests and will be communicated to the patient prior to the form or letter being completed by the provider. Please allow up to 10 business days for all forms/letters to be finalized, depending on the specific requests.

Social Media

The views and opinions that may be expressed on Summit Health and Wellness Center's social media profiles do not necessarily represent our thoughts and opinions and might include the views of others. Any information posted on social media is not to be assumed as medical advice or take the place of care that is being provided by a qualified healthcare provider. Should you submit any content to our social media sites, you understand and acknowledge this information is available to the public and Summit Health and Wellness Center is not responsible for any comments or responses posted. We will not provide any medical advice and/ or treatment recommendations on social media and encourage you to contact your healthcare provider.

Patient Portal

A patient portal is a secure online website that allows patients the convenience of having access to some personal health information. You can access the portal through the website. The patient portal will allow access to the patient's appointment reminders, lab results, medication refill requests, notifications from your Summit Health & Wellness Center and much more.

Acknowledgment and Receipt

I have reviewed the New Patient Policies and Procedures from Summit Health and Wellness Center and am aware that these policies are subject to change at any time.

Signature of patient/ Legal Representative: _____

Description of Legal Representative's Authority: _____

Date: _____

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Consent for Treatment

I consent to medical and/ or therapy treatment services for myself or the patient/ client for whom I am the parent or legally authorized representative. I understand that Summit Health & Wellness Center will share patient/ client health information according to federal and state law for treatment and operations.

Further, I understand the following information discussed in the appointment is held confidential and will not be shared without written permission except under the following conditions:

- The patient/ client threatens suicide.
- The patient/ client threatens harm to another person(s), including murder, physical harm, or assault.
- The patient/ client reports suspected child abuse, including but not limited to, physical abuse and/ or sexual abuse.
- The patient/ client reports abuse of the elderly.
- The medical provider is required by court order to provide privileged information.
- Based on clinical judgement, the provider may see fit to consult with another clinical and professional provider regarding your treatment.

State law mandates that mental health professionals must report these situations to the appropriate persons and/ or agencies.

Communication between the medical provider and patient/ client will otherwise be deemed confidential as stated under the laws of Oklahoma.

By signing below, I understand the above, and agree to these limits of confidentiality.

Signature of patient/ Legal Representative: _____
Description of Legal Representative's Authority: _____
Date: _____

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Patient Authorization for Release of Health Information (PHI)

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____

I request access to the following protected health information from my health record, maintained or created by the provider named below to the recipient named below.

☐ Entire Health Record
(Excludes Billing Records/Notes and Psychotherapy Notes*)

☐ Entire Health Record *
(Includes Billing Records/Notes)
(Excludes Psychotherapy Notes*)

☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain additional records.)

☐ Exchange of Verbal Communication

Or only these portions of my record:

☐ Billing Records
☐ X-ray Reports/Films
☐ Immunization Records
☐ Discharge Summaries
☐ Most Recent Progress Notes
☐ Pathology/Lab Reports
☐ Other _____
_____

Release Records From:			Provide Records To:		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Fax:	Phone:		Fax:	Phone:	

The information may be disclosed for the following purpose(s): ☐ Continued Treatment ☐ Legal ☐Insurance
☐ At my or my representative's request ☐ Other: _____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/ organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine the payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/ or non-communicable disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, HIV, or AIDS and/ or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/ organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.
- Reproduction of this authorization is as authentic as the original signed authorization.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature.

I, the undersigned, hereby acknowledge that I have read this authorization to its execution and fully understand the nature of the release.

Signature of patient/ Legal Representative: _____

Description of Legal Representative's Authority: _____

Date: _____

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Authorization to Consent to Treatment of Minor Without the Presence of Legal Guardian and/or Parent

Patient Name: _____ **DOB:** _____
First Last

I, the undersign parent(s)/ legal guardian(s), of the minor child listed above, DO AUTHORIZE the following names, to bring the minor to their appointment and assist in making decisions in the best interest of the minor. The providers of Summit Health and Wellness Center are able to provide mental health services to the minor in the absence of the parent or legal guardian.

It is understood that this consent is given in advance of a specific diagnosis or treatment being requires and is given to encourage the provider to exercise his or her best judgement as to the requirements of such diagnosis or mental health treatment in my absence.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s) or until the child may legally consent for him/ herself.

Individuals Allowed to Bring Minor
Name (First, Last): _____
Name (First, Last): _____
Name (First, Last): _____
Name (First, Last): _____

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____

Witness: _____ Date: _____

Phone: 405-310-3735
Fax: 405-310-3576
2770 Washington Dr. Suite 100
Norman, OK 73069
summithealthandwellnesscenter.com

SUMMIT
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Credit Card Guarantee for Personal Balance

The credit card guarantee ensures that your account stays up- to- date and current. Your care will be kept on file and only used when payment has not been made by mail or in person. You can make co-pays, pay for special services, or pay your bill with your credit card on file, if you choose. We will charge the amount due if payment has not been made in a timely manner. No show and/ or cancellations not made within 24 hours' notice will be charged to your credit card on file. Any balance that exceeds $200, will be charged for the balance in full.

☐ **Uninsured/ Self Pay Patients**

I understand that since I do not have insurance that I am personally responsible for payment. I understand that payment is due prior to the services rendered.

☐ **Insurance Assignment**

I understand that as a courtesy, Summit Health & Wellness Center, will bill my health insurance carriers, but that my bill (remaining balance) is MY responsibility. I understand that Summit Health & Wellness Center will wait up to 90 days for payment from my insurance provider. I understand that any amount owed after insurance has adjudicated a claim for services, which has not been paid by my insurance provider, will be due at the time of remittance has been received from the insurance company and placed on my designated credit card below unless other arrangements have been made and agreed upon in writing. Any insurance payments made on these claims thereafter will be placed on my account as a credit or will be refunded to me, if I so choose.

I understand that if my insurance does not cover the cost of mental health treatment, if my deductible is high, or there are other limitations in my coverage, that I will be responsible for my bill at the time of service.

I agree to the above terms and authorize you to charge any payment not paid by the date due.

Credit Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER
Card Holder's Name: _____
Card Holder's Billing Address: _____
Card Number: _____ **Exp Date:** _____/_____
Three Digit CID #: _____

Signature of patient/ Legal Representative: _____
Description of Legal Representative's Authority: _____
Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of patient/ Legal Representative: _____
Description of Legal Representative's Authority: _____
Date: _____

Expanded Authorization Option:
Please list any persons you would like to authorize to have access to your billing, appointment or health information* (ex: spouse, caretaker, or other family member):

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

*With the exclusion of information that is protected under State and Federal Law.

OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.
Date: _____ Initials: _____ Reason: _____

Phone: 405-310-3735
Fax: 405-310-3576
2770 Washington Dr. Suite 100
Norman, OK 73069
summithealthandwellnesscenter.com

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Informed Consent for Treatment with Psychoactive Medications

By reading the following conditions and signing my name at the bottom of this document, I acknowledge that I understand all the risks that are associated with psychoactive medications.

- The nature and seriousness of my mental condition for which the medication is recommended, and the reason for using the medication.
- Psychoactive medications have the potential for side effects. These side effects may involve, but are not limited to: the heart, nervous system, muscles, glands, urinary tract, bowels, blood eyes, skin, and allergic responses. Most side effects are minor and reversible; however, some side effects are serious, and may not be reversible such as tardive dyskinesia. I also understand that sudden death has been reported in association with stimulants in children with structural cardiac abnormalities.
- Monitoring serum concentration of some medications (ex: lithium, valproic acid, etc.) may be necessary. For patients prescribed second- generation antipsychotics, baseline and follow up monitoring of serum lipid and glucose concentration is recommended.
- Some medications have dependence and /or abuse potential (ex: stimulants, sedatives, anxiolytics, etc.) and may produce serious withdrawal symptoms upon abrupt discontinuation.
- Antidepressants increased the risk of suicidal thinking and behavior in short- term studies in children and adolescents.
- The improvement associated with psychoactive medications may be permanent or temporary. The medication will not cure the illness but is recommended to help alleviate the symptoms. Without the medication, mental condition may improve spontaneously, continue with little or no change, or worsen.
- The medication recommended and/ or dosage used may not be approved by the Food and Drug Administration for the assigned psychiatric diagnoses or for all the age groups. However, data does exist in support of the use for which the medication is recommended.
- Alternatives to treatment with medications are no treatment and/ or psychotherapy. I understand the prognosis with and without the recommended medication treatment.
- I have the right to accept or refuse this medication treatment and the right to revoke consent at any time prior to or during treatment. This consent is being granted without threat or coercion expressed or implied. No guarantees or assurances have been made concerning the results of treatment with this medication.
- I have been informed that if I have any questions or concerns about my mental health condition and/ or medication I may discuss them with my provider at my next visit.
- I understand that the patient is to take the medication only as prescribed and only for the condition which it is prescribed.
- I understand that it is the responsibility of the parent or guardian of the patient to contact the provider prescribing the medication for questions or concerns regarding the effect, or side effects of the prescribed drug or, in the event of a medical emergency, emergency personnel.

I have read, or the provider has read and explained to me, and I do understand foregoing risks that are associated with psychoactive medications. I have had the opportunity to have my questions answered. I understand the nature, purpose, and expected benefit of the recommended medication, the diagnosis and prognosis of the condition for which the medication is recommended, the alternatives to medication treatment including no treatment, and the significant risks and common side effects for the recommended medication. I do hereby give informed consent to the agreed upon treatment for the medications prescribed by the provider.

Signature of patient/ Legal Representative: _____

Description of Legal Representative's Authority: _____

Date: _____

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Controlled Substances Agreement

Controlled substance medications (narcotics, stimulants, tranquilizers, hormones) are very useful, but have a high potential for tolerance, dependence, and misuse. Therefore, these medications are closely monitored by local, state, and federal governments. As a patient of Summit Health and Wellness Center, I agree to the following **(please initial):**

_____ 1.) I am responsible for the controlled substance medications prescribed to me. If my prescriptions are misplaced, stolen, or if "I run out early", I understand this medication will not be replaced regardless of the circumstances.

_____ 2.) Refills of controlled substance medications will be made only during regular office hours. Refills will not be made on the same day as requested, nights, holidays, or weekends. I will not excessively call the office seeking a refill if I have already been denied a refill. A 72-hour notice must be made to allow staff and provider sufficient time to research and proceed with the request.

_____ 3.) I may be asked to perform a routine urine test and acknowledge my insurance may not pay for this test resulting in me being financially responsible for reimbursement to Summit Health & Wellness Center.

_____4.) I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or the concomitant use of non- prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____ 5.) I will not increase my controlled substance medication on my own.

_____ 6.) I will attend my scheduled appointments regularly. Frequently missed and/ or rescheduled appointments may result in the inability to obtain a medication refill.

_____ 7.) I understand that I am prescribed medications to assist in reaching treatment goals. I agree I need to adhere to the treatment plan as suggested by my healthcare provider.

_____ 8.) I understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, utilizing other illicit drugs, failure in taking the medication as prescribed, or abuse of controlled medications, I may be subject to dismissal from this facility.

_____ 9.) I will not request or accept controlled substance medications from any other provider (including emergency rooms, dentist, etc.) while I am receiving such medication from any provider at Summit Health & Wellness Center.

I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know some individuals can develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and doing so can result in an increase in the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks. Therefore, when I need to stop this medication, I must do so slowly and under medical supervision, or I may experience withdrawal symptoms. By signing below, I understand and accept the above agreement.

Signature of patient/ Legal Representative: _____
Description of Legal Representative's Authority: _____
Date: _____

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Pediatric Demographics

Patient Information

Patient Name:_____
First Middle Last

Preferred Name: _____ Date of Birth: _____/_____/_____

SSN: _____-_____-_____ Sex: ☐ Male ☐ Female ☐ Other Race: _____

Ethnicity: _____ Primary Language: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: (_____)_____ Alt. Phone: (_____)_____

Email: _____ Send Appointment Reminders via: ☐ Text ☐ Call ☐ Both

Primary Care Provider:_____ Therapist: _____

Referred by: _____

Parent/ Guardian Information

☐ Mother ☐ Stepmother ☐ Guardian ☐ Foster Mother

Name:_____
First Middle Last

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: _____ City: _____ Zip Code: _____

Cell Phone: (_____)_____ Alt. Phone: (_____)_____

Employer: _____ Occupation: _____

Email: _____

Do You Have Legal Custody of this Child? ☐ YES ☐ NO

☐ Father ☐ Stepfather ☐ Guardian ☐ Foster Father

Name:_____
First Middle Last

Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Address: _____ City: _____ Zip Code: _____

Cell Phone: (_____)_____ Alt. Phone: (_____)_____

Employer: _____ Occupation: _____

Email: _____

Do You Have Legal Custody of this Child? ☐ YES ☐ NO

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Emergency Contact

Primary Contact: _____ Relation to Patient: _____
First Last

Address: _____ City: _____ Zip Code: _____

Cell Phone: (_____)_____ Alt. Phone: (_____)_____

Secondary Contact: _____ Relation to Patient: _____
First Last

Address: _____ City: _____ Zip Code: _____

Cell Phone: (_____)_____ Alt. Phone: (_____)_____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____ Pharmacy Phone: (_____)_____

Primary Insurance Information

Insurance Company Name: _____ Phone Number: (_____)_____

Policy Number (Member ID): _____ Group Number: _____

Plan Name: _____ Effective Date _____/_____/_____

Subscriber Name: _____ DOB: _____/_____/_____
First Last

Subscriber's SSN: _____-_____-_____ Relation to Patient: _____

Secondary Insurance Information

Insurance Company Name: _____ Phone Number: (_____)_____

Policy Number (Member ID): _____ Group Number: _____

Plan Name: _____ Effective Date _____/_____/_____

Subscriber Name: _____ DOB: _____/_____/_____
First Last

Subscriber's SSN: _____-_____-_____ Relation to Patient: _____

I hereby give lifetime authorization for payment of insurance made directly to Summit Health & Wellness Center LLC and any assisting providers, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature of Patient/ Guardian: _____

Date: _____

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Pediatric Intake Form

Patient Name: _____ DOB:_____

Current Areas of Concern:

Social and Personal Adjustment

- ☐ Anxious or excessive worry
- ☐ Sadness or appearing down
- ☐ Physically aggressive towards others or self
- ☐ Verbally aggressive towards others
- ☐ Temper tantrums or emotional meltdowns
- ☐ Shyness or withdrawn around others
- ☐ Behaviors that appear unusual or bizarre
- ☐ Difficulty with peers and relationships
- ☐ Alcohol or drug problems
- ☐ Legal troubles
- ☐ Harms self or others

School Adjustment

- ☐ Difficulty with classmates
- ☐ Difficulty with authority
- ☐ Academic problems
- ☐ Excessive tardiness or absences
- ☐ Behavior problems
- ☐ Learning disabilities
- ☐ Attention or focus concerns
- ☐ Frequent physical complaints while at school

Family Adjustment

- ☐ Child- parent concerns
- ☐ Conflicts with siblings
- ☐ Recent family dynamic changes (ex. Divorce, death, etc.)
- ☐ Mother or father experiencing difficulties
- ☐ Drug or alcohol use or abuse
- ☐ History of trauma or loss
- ☐ History of domestic violence in the home
- ☐ Abuse

Developmental or Physical Concerns

- ☐ Sleeping concerns
- ☐ Eating concerns
- ☐ Grooming or showering concerns
- ☐ Speech or language delay or concerns
- ☐ Fine motor coordination concerns
- ☐ Gross motor coordination concerns
- ☐Other:_____

_____

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Psychiatric History

Previous mental health diagnosis:

_____

_____

_____

Please list all CURRENT medications (over the counter, prescribed, or supplements):

_____

_____

_____

_____

Please list all PREVIOUS psychiatric medications (ex: antidepressants, antipsychotics, etc.):

_____

_____

_____

Previous psychiatric hospitalizations? ☐ Yes ☐ No – If yes, when, where, and why?

_____

_____

Previous self-harm or suicide attempts:_____

_____

Is child currently seeing a therapist? ☐ Yes ☐ No – If yes, who? _____

Medical History

Current diagnosed medical problems:_____

_____

_____

Past medical problems, hospitalizations, surgeries:_____

_____

_____

Allergies:_____

_____

Does the child wear corrective lenses or have vision deficits? ☐ Yes ☐ No

Does the child wear hearing aide devices or have hearing deficits? ☐ Yes ☐ No

School History

Current School: _____ Grade Level: _____

Teacher's Name: _____

Ever been retained: ☐ Yes ☐ No Current IEP or 504: ☐ Yes ☐ No Gifted or honors classes: ☐ Yes ☐ No

Any current teacher complaints? _____

_____

Extracurricular activities?_____

_____

_____

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Family History

Do any of the child's family members have a mental health diagnosis?_____

_____

_____

Review of Systems

What symptoms is the patient currently experiencing?

Constitutional: ☐ Weight loss ☐ Weight gain ☐ Poor appetite ☐ Fatigue ☐ Insomnia ☐ Tiredness

Eyes: ☐ Blurry vision ☐ Eye discharge ☐ Dry eyes ☐ Eye redness ☐ Decrease in vision ☐ Double vision

ENT: ☐ Ear pain ☐ Hearing loss ☐ Tinnitus ☐ Sinus problems ☐ Congestion/ cough ☐ Hoarseness

Cardiovascular: ☐ Chest pains ☐ Palpitations ☐ Rapid heartbeat ☐ Fainting

Respiratory: ☐ Shortness of breath ☐ Cough ☐ Excessive sputum ☐ Difficulty breathing

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Reflux

Genitourinary: ☐ Frequent urination ☐ Bed wetting ☐ Urgency ☐ Painful urination ☐ Blood in urine

Musculoskeletal: ☐ Joint pain ☐ Muscle pain/ aches ☐ Weakness ☐ Joint swelling ☐ Leg cramps

Skin: ☐ Rash ☐ Blisters ☐ Itching ☐ Hives ☐ Hair loss ☐ Skin sores ☐ Mole changes

Endocrine: ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive thirst ☐ Excessive sweating

Neurological: ☐ Migraines/ headaches ☐ Dizziness ☐ Tremors ☐ Numbness ☐ Seizures

Allergy/ Immune: ☐ Hay fever ☐ Allergic reactions ☐ Frequent infections ☐ HIV ☐ Hepatitis

Psychiatric: ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Hallucinations ☐ Mania

Substance Use History

Any history of alcohol use? ☐ Yes ☐ No

If yes, how much at one time and how often? _____

Any history of recreational (street) drugs? ☐ Yes ☐ No

If yes, how often and what kind?_____

_____

Any history of cigarette smoking? ☐ Yes ☐ No If yes, how many per day? _____

Is the patient interested in quitting? ☐ Yes ☐ No

Has the patient ever abused prescription drugs? ☐ Yes ☐ No

If yes, which ones?_____

_____

Trauma History

Has the child ever witnessed or experienced any abuse? ☐ Emotional ☐ Sexual ☐ Physical ☐ Neglect

How old was the child when this occurred? _____

By Whom: _____

Details:_____

_____

_____

_____

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Prenatal History

Was the mother's pregnancy healthy? ☐ Yes ☐ No

If no, what occurred? _____

Did she receive prenatal care? ☐Yes ☐ No

How old was the mother at child's birth? _____

Did the mother have any exposure to drugs, alcohol, tobacco, or excessive caffeine? ☐ Yes ☐ No

If yes, which? _____

Was the child born: ☐ Preterm ☐ Term ☐ Post-term

Child's birth weight? _____

Delivery: ☐ Vaginal ☐ Breech ☐ Forceps ☐ Suction ☐ Cesarean

Any complications after delivery?_____

_____

Developmental History

Did or does your child have any eating problems? ☐ Yes ☐ No

How many meals a day does the child eat? _____

Did or does your child have any sleeping problems? ☐ Yes ☐ No

How many hours of sleep does your child get per day? _____

Naps? _____

Were there any health or congenital problems in early infancy? ☐ Yes ☐ No

Was it difficult to care for your child as an infant? ☐ Easy ☐ Average ☐ Difficult

How does your child behave around other people? ☐ More sociable than others ☐ Average ☐ Very unsociable

How would you rate the child's activity level? ☐ Very active ☐ Average ☐ Not active

Age child sat up: ☐ 3- 6 months ☐ 7- 12 months ☐ Over 12 months

Age child crawled: ☐ 6- 12 months ☐ 13-18 months ☐ Over 18 months

Age child walked unassisted: ☐ Under 1 year ☐ 1- 2 years ☐ Over 2 years

Age child spoke words other than "mama" or "dada": ☐ 9- 12months ☐ 13- 18 months ☐ 19- 24 months

Age toilet trained?

Bladder: ☐ Under 1 year old ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years

Bowel: ☐ Under 1 year old ☐ 1-2 years ☐ 2-3 years ☐ 3-4 years

If female, has your child started her menstrual cycle? ☐ Yes ☐ No

If yes, how old was she when it began? _____

Is your child dating? ☐ Yes ☐ No

Is your child sexually active? ☐ Yes ☐ No ☐ Unknown

How many hours per day is your child on screen time (iPad, Xbox, etc.)? _____

Is your child working? ☐ Yes ☐ No

Does your child have their driver's permit or license? ☐ Yes ☐ No